

**Testimony of Andrea Armstrong
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**Before the Permanent Subcommittee on Investigations of the
U.S. Senate Committee on Homeland Security and Governmental Affairs Committee**

**Hearing on
“Uncounted Deaths in America’s Prisons and Jails: How the Department of Justice Failed
to Implement the Death in Custody Reporting Act”**

Chairman Ossoff, Ranking Member Johnson, and Members of the Subcommittee:

Thank you for holding this hearing and for the opportunity to testify. My name is Andrea Armstrong. I am a law professor at Loyola University New Orleans, College of Law. I teach in the areas of criminal and constitutional law and research incarceration law and policy. I have visited prisons and jails across the country, including participating in audits of detention facility operations. My students and I created the Incarceration Transparency project and website, which collects, publishes and analyzes individual and facility-level records of deaths in custody in Louisiana prisons, jails, and detention centers. I also collaborate with researchers in eleven other states to collectively problem-solve data transparency issues for deaths in custody.

Introduction

Today, I focus my testimony on the critical importance of federal collection and publication of data on deaths in custody under the Death in Custody Reporting Act (DCRA) and the experiences of myself and my students in collecting this data in Louisiana for our Incarceration Transparency project. The work of your subcommittee is a vital part of our democratic tradition of transparency and accountability of public institutions. Through your efforts, we can ensure that our prisons, jails, and detention centers in the U.S. fulfill their constitutional obligations and perform as expected.

Just a few weeks ago, I received an email requesting assistance after he was told that the prison would not provide any specific information about the death of his “little brother.”¹ He described his brother as a “pretty healthy young man” and wrote that “correctional facility is not telling us anything. They said that we needed a lawyer if we wanted more information.”² Experiences like these decrease public trust in our criminal justice system and the ability of prisons to provide fair and appropriate punishment.

My testimony today is composed of three parts. First, I highlight our project’s findings on deaths in custody in Louisiana and how we use federal death in custody data collection. Second, I explain why deaths in custody (and data collection) matter for public policy. Third, I identify significant problems with recent changes in the federal efforts to collect information about deaths

¹ Confidential correspondence to Andrea Armstrong, on file with author (Aug. 20, 2022).

² *Id.*

in custody. Fourth, based on my research and the research of others around the country, I identify several tools to potentially improve transparency of deaths in custody with the aim of reducing preventable deaths in our nation's prisons, jails, and detention facilities.

I. Louisiana Deaths in Custody 2015-2019

In Louisiana, no one knew why and how people died behind bars in our state's prisons, jails, and detention centers prior . Louisiana leads the nation in incarceration.³ We hold more people, per capita, than any other state in the South, easily outpacing our neighboring states. We are also increasingly holding people for other states and federal immigration authorities. At the same time, prisons, jails, and detention centers in Louisiana operate without independent oversight, mandatory standards, or public transparency.

Families, elected officials, and journalists lacked concrete information about deaths in custody. More often than not, they wanted to understand whether a recent death in custody was unique compared to other deaths and no one could answer their questions. National data from the U.S. Department of Justice's (DOJ) Bureau of Justice Statistics (BJS) wasn't helpful because BJS reports only report state outcomes, not facility outcomes.

Parish jails, which also house approximately 50% of our state prison population,⁴ are only required to report deaths of people detained pending trial to their local coroner. Prisons, parish jails, and private prisons are only required to report deaths of people serving sentences to the Louisiana Department of Public Safety and Corrections (DPSC) headquarters and the local coroner. Some facilities, but not all, will issue individual press releases when a death behind bars occurs.⁵ DPSC publishes limited and generalized data on causes of death for incarcerated people convicted of a crime in its quarterly Briefing Book. However, because DPSC does not provide demographic or facility information, it is impossible to identify broader patterns in deaths in custody.

A. Project Description and Findings

Since August 2019 law students at Loyola New Orleans have filed annual public records requests with 132 facilities, including all prisons, jails, juvenile detention centers (state and locally operated), and federal facilities. Students requested records of deaths in custody, including any records prepared and submitted to BJS or for deaths in 2020 to present, submitted to the Louisiana Commission on Law Enforcement (LCLE), the state coordinator for the Bureau of Justice

³ Emily Widra & Tiana Herring, *States of Incarceration: The Global Context 2021*, PRISON POL'Y INITIATIVE (Sep. 2021), <https://www.prisonpolicy.org/global/2021.html>.

⁴ Jails and private operators currently receive a per diem rate from the state of \$26.39 per person, up from \$24.39 during the project study period. Jails and private corporations received approximately \$175 million in payments from the state in fiscal year 2019-2020. La. Dep't Pub. Safety & Corr., *Briefing Book*, 76 (July 2020).

⁵ See also M. Forrest Behne et al., *When It Comes To Reporting Deaths of Incarcerated People, Most States Break the Law*, the Appeal (Mar. 2, 2022)(noting frequency of press releases does not match data reporting for certain states.)

Assistance (BJA).⁶ Students also reviewed news and court litigation databases for their assigned parishes (counties) to identify unreported deaths occurring behind bars.

We found that at least 786 people died behind bars in Louisiana from 2015-2019. Black men ages 55-60 serving a sentence post-conviction are the largest impacted population by deaths behind bars, comprising 11% of all known deaths. Of the over 100 local jails in the state, East Baton Rouge Parish, Jefferson Parish, and Orleans Parish had the highest numbers of deaths. Fourteen percent of all known deaths behind bars were pre-trial, including two juveniles.

Our findings are based on responses from 69% of the facilities in the state. The remaining facilities did not respond to our repeated public records requests over two years, in violation of Louisiana Public Records Act § 44:1 et seq. The project has also not received any death data from federal agencies operating detention centers in Louisiana, which is particularly troubling as the number of people detained for immigration violations has soared since 2017.⁷ In contrast, the state DPSC, which administers eight state prisons holding approximately 16,000 people, fully responded to our requests and also sent responses for people legally under their custody but serving their sentence in local jails.

Our first report, attached as Exhibit 1, provides the most comprehensive analysis of deaths behind bars in Louisiana to date. The full findings are detailed in the attached exhibit, however several are worth highlighting here:

1) The majority (53%) of deaths due to medical illness were not from a pre-existing condition at time of admission.

Significance: Pre-existing condition data illustrates the importance of carceral health care. Prisons and jails are the exclusive source for diagnosing and treating diseases for the majority of medical-related deaths.

2) Drug related deaths occurred long after admission to the facility, though a sizable number occurred within the first week for jails.

Significance: Drug related deaths occurring long past admission to the secure facility implicate the adequacy of facility security and contraband policies.

3) Two-thirds of deaths due to violence occurred in cells, the majority of which involved assaults and blunt force trauma leading to head injuries.

Significance: This may indicate that the deadly violence was not a product of contraband or homemade weapons, but does implicate the adequacy of facility supervision and observation policies.

⁶ BJS Forms collected include CJ-9/CJ-9A (jails), NPS-4/NPS-4A (prisons), CJ-10/CJ-10A (private facilities) and NPS-5/NPS-5A (juveniles). Students also received correspondence from some facilities indicating there were zero deaths in that facility.

⁷ See Laila Hlass & Mary Yanik, *No End in Sight: Prolonged and Punitive Detention of Immigrants in Louisiana*, 3, TUL. UNIV. IMMIGR. L. CLINIC (May 2021).

4) Forty-three percent of all completed suicides in parish jails occurred in segregation cells compared to 7% in state prisons. Two out of three juvenile suicides occurred in segregation housing. Juvenile suicides occurred most often in the evenings.

Significance: Suicides in segregation are of particular concern, since segregation settings usually entail a higher level of individual supervision or observation than general shared cell or dorm settings. In addition, segregation cells are typically associated with more restrictive policies on items allowed in a segregation cell. The timing of the juvenile suicides may also point towards staffing and programming options in the evenings.

Our report, the full dataset, and a searchable database of all death records collected are all available online. Our choice to widely publish this data and our analysis was a deliberate effort to increase transparency of Louisiana’s detention facilities. I have also shared our research and print copies of the report with community groups, the Louisiana Sheriff’s Association and the Louisiana Department of Public Safety & Corrections, all of whom agreed the research was helpful for their efforts.

II. Deaths in Custody Matter

Every person who dies in a prison, jail, or detention center belongs to a family and community. Prison Policy Initiative, a non-partisan research organization, estimates that in 2021, 1.9 million people were behind bars in the United States.⁸ How and why a person died in custody, however, is often kept secret, even from family members and relatives. As a result of my research, I am often contacted by family members seeking assistance in getting more information about the death of their loved one. For some families, our project is the first time they have seen official records on the death of their loved one. For example, a grieving family was told they would need to pay \$500 in public records fees to obtain information about their cousin’s apparent suicide in a local jail.⁹ Unable to afford the fee, the family mourned while never understanding how and why he died. Seven years after his death in 2015, our project was able to obtain the records and worked with a family member to ensure they had support in place to revisit this traumatizing period of their lives.

Beyond the significant impact on families, this lack of transparency on deaths in custody undermines our nation’s commitment to public safety. People, both free and incarcerated, are less likely to trust a system that hides vitally important information.¹⁰ It is also impossible to fix what is invisible and hidden. As Justice Brandeis wrote, “[p]ublicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.”¹¹ Increasing public transparency on deaths in custody is critical step towards ultimately reducing deaths in custody.

⁸ Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2022*, PRISON POL’Y INITIATIVE (Mar. 14, 2022), <https://www.prisonpolicy.org/reports/pie2022.html>

⁹ Confidential correspondence Andrea Armstrong, on file with author (Nov. 14, 2021, Nov. 30, 2021, Dec. 17, 2022, Feb. 3, 2022, Feb. 8, 2022, Mar. 7, 2022)

¹⁰ See Jonathan Jackson et al., *Legitimacy and Procedural Justice in Prisons*, 191 PRISON SERVICE J. 4 (2010).

¹¹ Louis Brandeis, *OTHER PEOPLE’S MONEY AND HOW BANKERS USE IT*, 92 (1914).

Deaths in prisons, jails, and detention center are also important in light of these facilities' constitutional obligation to protect the health and safety of people in their custody.¹² This obligation includes preventing violence, providing emergency and regular medical and mental health care, and ensuring staff are properly trained to recognize and respond to life-threatening distress.

A. Deaths in custody should be rare events

Deaths in custody are an urgent matter of public concern. The overwhelming majority of people who die in custody have not been judicially sentenced to death. According to the BJS data from 2001 to 2018, 86,173 people died nationwide in jails and federal and state prisons.¹³ Less than 1% of those deaths were judicially sentenced to death by a court as punishment for their crime.¹⁴ While some medical-related deaths in prisons are to be expected due to life sentences, non-medical deaths in prisons and all deaths in jails and detention centers demonstrate that unexpected deaths behind bars also occur. Approximately 20% of deaths of people in jails and state and federal prisons nationally were of people detained pretrial from 2001-2018.¹⁵ Given the presumption of innocence for people detained in jails, deaths of individuals pre-trial are particularly concerning.

Another reason that deaths behind bars should be rare is because incarcerated people do not (or should not) have access to illegal drugs and motor vehicles. For non-incarcerated people, poisoning (accidental overdoses) and motor vehicle accidents are two of the most prevalent accidental causes of death.¹⁶ Accidental causes of death were the third highest cause of death for non-incarcerated people in 2019.¹⁷ Carceral spaces, by definition, are highly controlled areas that regulate the movement and behavior of people within them.¹⁸ For people who visit, work, or live in these secure facilities, entrance and exit from the facility is monitored and subject to search,

¹² In general, the Due Process Clause of the Fourteenth Amendment governs conditions for people held pretrial (*Bell v. Wolfish*, 441 U.S. 520 (1979) (applying Fourteenth Amendment) and in a majority of circuits, to youth held in detention centers (Rudy Estrada & Jody Marksamer, *The Legal Rights of Young People in State Custody*, 5, 13 n. 28 (June 2006)), while the Eighth Amendment's prohibition of "cruel and unusual punishment" applies to people held pursuant to a conviction (*Estelle v. Gamble*, 429 U.S. 97 (1976) (applying Eighth Amendment).);

¹³ National death data was compiled from the following three resources: E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN STATE AND FEDERAL PRISONS 2001-2018- STATISTICAL TABLES, 2 (2021) (reporting 67,874 deaths in federal and state prisons), [hereinafter MORTALITY IN STATE AND FEDERAL PRISONS]; E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN LOCAL JAILS 2001-2018-STATISTICAL TABLES, 6 tbl.1 (2021), [hereinafter MORTALITY IN LOCAL JAILS 2001-2018] (reporting a total of 11,106 deaths from 2008–2018).; Margaret Noonan, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN LOCAL JAILS 2000-2007, 7 tbl.8 (2010) (listing total number of deaths 2000–2007; for the years 2001–2007, 7,193 people died in custody in jails). Thus, the total number of deaths in jails 2001–2018 is 18,299.

¹⁴ See Tracy Snell, Bureau of Just. Stat., U.S. Dep't of Just., CAPITAL PUNISHMENT 2020 – STATISTICAL TABLES, 18 (Dec. 2021).

¹⁵ See note 13.

¹⁶ Jiaquan Xu, Sherry L. Murphy, Kenneth D. Kochanek, & Elizabeth Arias, *Deaths: Final Data for 2019*, 70 *National Vital Statistics Reports* 1, 43 (July 26, 2021) (Table 7 indicating subcategories of accidental death).

¹⁷ *Id.* at 1.

¹⁸ See John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: A Report of The Commission on Safety and Abuse in America's Prisons*, VERA INST. FOR JUST., 445 (June 2006).

limiting the introduction of contraband items inside the facility.¹⁹ Similarly, as a deliberately contained population that does not have freedom of movement, incarcerated individuals are less likely to encounter the safety hazards of road travel.

Third, healthcare and other life-saving measures are potentially physically closer for emergencies than in the free world. Prison and jail administrators often point to the poor health of people admitted to their facilities as a contributing factor to deaths in custody. Available data does indicate a higher burden of significant medical conditions for incarcerated people, including chronic diseases like hypertension, diabetes, hepatitis, and asthma.²⁰ However, as discussed more fully in Part I, the majority of medical-related deaths in Louisiana were not from medical conditions diagnosed before entering the prison or jail. Instead, these conditions developed after admission to the facility. This data helps us understand the importance of providing constitutionally adequate health care, including timely diagnosis, treatment, and emergency care. Similarly, these facilities are staffed and operated 24 hours a day, 7 days a week. Thus, for medical emergencies or violent assaults, emergency or stabilizing assistance is usually physically closer for incarcerated people.

Deaths in custody can also be expensive for taxpayers, even with legal doctrines that limit recovery for wrongful deaths behind bars. Settlements and legal judgments for preventable deaths behind bars can cost millions of dollars, in addition to the significant expenditures to defend against these wrongful death cases. In one of the largest settlements for wrongful death behind bars in California, Alameda County and Corizon Health Inc, the private health care provider, agreed to pay 8.3 million dollars for the death of Martin Harrison.²¹ Insurance premiums for facilities may also increase where there is evidence of prior wrongful deaths. A study of deaths in East Baton Rouge Parish Prison found that insurance premiums for that facility, in which 44 people died from 2012 to 2020, increased by 71% from 2011 to 2018.²² Higher legal standards for proving wrongful death while incarcerated and the qualified immunity doctrine, which requires proof of violation of a clearly established constitutional or statutory right, limit recovery for families of decedents.²³ By limiting the financial costs of preventable deaths, these doctrines also limit the incentives for facilities to improve their policies and procedures to prevent future deaths.

Last, deaths in custody are significant because patterns in deaths behind bars may signal broader challenges in the prison, jail, or detention center. For example, if suicides tend to occur in certain jail cells, this could be an indication that those cells may be less observable from the guard station in a particular unit. In response, facilities could increase their required patrols in those areas or arrange for people on suicide watch to be housed closer to medical personnel.

¹⁹ See *Florence v. Bd. of Chosen Freeholders of Cty. of Burlington*, 566 U.S. 318, 326-329 (2012) (discussing rationale and case law on contact visits & searches of people admitted); *Walter Pavlo Corrections Officers Often Key to Contraband Introduced Into Prison*, FORBES (Sep. 30, 2021).

²⁰ Ingrid Binswanger et al. *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population*, 63 J. OF EPIDEMIOLOGY & COMM. HEALTH. 912-19 (2009).

²¹ Henry K. Lee, *\$8.3 Million Settlement in Death of Alameda County Inmate*, SFGATE.COM (Feb. 10, 2015).

²² Andrea Armstrong & Shanita Farris, *Dying in East Baton Rouge Parish Prison*, 22 (2018).

²³ For a more robust discussion of qualified immunity and higher standards of proof for wrongful death claims by family members of incarcerated decedents, see Andrea Armstrong, *Prison Medical Deaths and Qualified Immunity*, 112 J. CRIM. L. AND CRIMINOLOGY 79 (2021).

Similarly, if facility administrators see a pattern of heart disease deaths at younger than average ages, this may have implications for the food and exercise allowed for incarcerated people. The time of day for intentional incidents causing death, such as violence or suicide, may highlight a need for more robust programming or security during certain parts of the day to prevent future incidents.

B. Data collection is essential to fully understand the problem

Simply put, if we don't collect the data, we can't understand how and why people are dying while incarcerated. We also can't determine how many of the deaths are preventable. Homer Venters, a physician, epidemiologist and the former Chief Medical Officer of the NYC Correctional Health Services, has argued that a significant portion of deaths at Rikers Island jail were in fact preventable. Expert panels, including correctional administrators, have stressed the importance of accurate, more granular, and timely data for creating targeted interventions to reduce deaths.²⁴

Chief medical examiners across the country have also emphasized the value of standardized reporting of deaths in custody. The National Association of Medical Examiners has issued a position paper proposing standard definitions, uniform investigation and autopsy practices, and statistical reporting.²⁵ Standardizing these practices, they argue, would increase "reliability and consistency" and "instill confidence in the medical examiner/forensic pathologist/coroner's independence by the criminal justice system, public health authorities, and the community at large."²⁶

Facility-level data and detailed information about who dies in government custody is a difficult undertaking. Currently and historically, there is no single national source for data at the facility-level. While there is federal data collection under the Death in Custody Reporting Act, authorized by Congress, and analysis by state, these efforts have been dogged by non-compliance and vague definitions, providing only a broad overview of the causes of death. There are also challenges obtaining information when a state houses people from a different jurisdiction, but neither state reports the death. Recent changes internally by the DOJ on which bureau collects the data has also complicated data collection efforts.

III. Challenges in DCRA Reporting

A. DOJ-Bureau of Justice Statistics (BJS) Implementation

BJS has episodically published separate mortality reports for jails and prisons, with their latest reports for each (December 2021) analyzing data from 2000-2019. The data was collected via a

²⁴ See Joe Russo et al., *Caring for Those in Custody: Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities*, 21-22, RAND Corporation (2017).

²⁵ Roger Mitchell, et. al., *National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody*, 7 ACADEMY OF FORENSIC PATHOL. 604 18 (2017).

²⁶ *Id.* at 606.

standard survey and submitted by each state and local jurisdiction directly to the federal government. Officials completed the survey regardless of whether or not a death occurred.

The data released by BJS, however, does not provide for analysis by facility and state data is not disaggregated by race, age, or length of stay. Moreover, it is impossible to determine the completeness of the BJS data, particularly for jails, without a facility-level accounting of reporting institutions. Nevertheless, as the sole source of national and comparative data, the data collected by BJS through 2019 is critically important, and in our experience, superior to data subsequently collected through BJA.

B. DOJ-Bureau of Justice Assistance (BJA) Implementation

The transition of data collection to BJA has created significant difficulties on the ground for continued data collection.²⁷ As part of the transition, facilities were required to report deaths in custody to a central state office, which would collect the responses and submit them to federal authorities online. Facilities with zero deaths were not required to report, however, BJA could sanction jurisdictions that failed to report deaths in custody.

For 2020, the Louisiana Commission on Law Enforcement (LCLE), the central state agency responsible for BJA reporting, submitted a total of 6 deaths in custody for the state of Louisiana, the majority of which were from one parish.²⁸ In contrast, Loyola Law students, through public records requests and media searches, identified 180 deaths in Louisiana prisons and jails in 2020. Multiple sheriffs also informed our students that they were no longer required to report deaths in custody for federal data collection. (Exhibit 2).

If Louisiana's experience is similar to those of other states, 2020 will be the first year in two decades in which the federal government can not provide overall or comparative data on the causes of deaths in prisons, jails, and detention centers nationwide. In addition, it is unclear if BJA adopted any sanctions against Louisiana.

The gap in data during 2020 could not have occurred at a worse time. A report published by the Univ. of Texas-Austin found that state and particularly local facility reporting on Covid infections and reporting varied widely across the U.S., creating large gaps in data at a critical public health moment.²⁹ The authors concluded:

This data gap means that policymakers, stakeholders, and the public do not know whether people in custody or the staff that work in these facilities are safe during this public health crisis; they cannot assess the

²⁷ See also M. Forrest Behne et al., *supra* note 5 (reviewing state compliance with DCRA and making recommendations) .

²⁸ Correspondence with Bob Wertz, Law Enforcement Training Manager, Louisiana Commission on Law Enforcement (Apr. 12, 2022) with excel file attachment "Copy of Death-in-Custody-Reporting-Act-2022-04-12-Request" received via email pursuant to public records request with names redacted.

²⁹ Michele Deitch & William Bucknall, *Hidden Figures: Rating the Covid Data Transparency of Prisons, Jails, and Juvenile Agencies*, Covid, Corrections, & Oversight Project at Univ. of Tex.-Austin (Mar. 2021).

risks to surrounding communities; and they do not know if correctional management approaches and policy responses are effective or equitable.³⁰

Academic researchers have attempted to fill the gap in data, most notably for data around Covid-related deaths in prisons, jails, and detention centers. The UCLA Covid Behind Bars Data Project³¹ began as a volunteer project to track mortality in all fifty states in real-time to support reforms that would reduce deaths in custody. It has since become an authoritative though unofficial and non-governmental source on deaths in custody.

For deaths occurring in 2021, LCLE reporting improved and included 191 deaths.³² However, our initial review indicates our data collection provides significantly more detail on the circumstances of death than the data provided to BJA. For example, our records generally include the specific cause for medical deaths and the facility where the person was housed, even if he or she ultimately died in an external medical facility. In contrast, LCLE data provided to BJA only indicates if the death was due to “natural causes,” without specifying the specific illness that caused the death. Thus, even with improved reporting, the Department of Justice will no longer be able to analyze medical causes of death and determine whether they are consistent with mortality causes in the general population.

C. Changes in death survey from BJS to BJA

To better understand the impact of moving death in custody data collection from BJS to BJA, I analyzed the survey instruments for both agencies. Some information will not be collected at all under BJA and even when it is collected, it provides less specificity than the BJS data collection. (A full comparison of the two data instruments is attached as Exhibit 3).

The following types of important information are no longer available under the BJA data series:

- **Facility population and admissions information**

This data is required to calculate mortality rates for local and state jurisdictions.

- **Facilities with zero deaths**

This data is important for prison and jail administrators to identify best practices, promote cross-facility learning, and replicate implementation.

- **Decedent specific data, including trial status, location of deaths and incidents leading to deaths, & pre-existing conditions, among others**

This data is essential for facilities to review their existing policies, procedures and operations to identify areas for improvement, including in security, medical, facility layout, and housing assignments. Trial status will be significant for those states, like Louisiana, that also house people convicted of state offenses in local jails.

³⁰ *Id.* at 5.

³¹ <https://uclacovidbehindbars.org>; see also Brendan Saloner et al., *Research letter: COVID-19 Cases and Deaths in Federal and State Prisons*, JAMA (2020)(relying data from the UCLA Covid Behind Bars Project)..

³² *Id.*

- **Specific illnesses for medical-related causes of death.**

This data is critical for understanding the healthcare challenges for prisons, jails, and detention centers, as well as for statistical comparisons to causes of death for non-incarcerated populations.

IV. Tools to Reduce Deaths in Custody through Transparency

The lack of data on deaths in custody deprives taxpayers of critical information to understand the operations of their prisons, jails, and detention centers. It also undermines public trust in government agencies, while also depriving agency leaders of information needed to reduce deaths in their custody. Congress has a range of tools to address the current lack of transparency (including robust reporting and data collection) on deaths in custody, including:

A. DCRA 2013

DCRA 2013 could be amended to require data collection on all elements previously collected by BJS, including but not limited to restoring population/admissions, trial status, date of birth/age, housing status, specific medical illness, pre-existing conditions, & location of incidents/death categories. An amended DCRA could also require submission from all jurisdictions, regardless of whether or not a death occurred and that all jurisdictions with deaths identify whether or not the death is attributable to the jail. In addition, an amended DCRA could clarify reporting obligations between jurisdictions, where a state houses a person on behalf of another state. There is also an opportunity to improve upon the prior data collection efforts under BJS, by requiring publication of facility level data. Adopting these amendments would improve our understanding of current deaths in custody, including potential disparities. It would also allow for analytical comparisons to the almost 20 years of data previously collected.

B. Bi-partisan Congressional working committee

This bipartisan working committee could provide a key source of accountability for implementation of DCRA by monitoring state and DOJ compliance with DCRA. Members of the committee could review the quarterly reports of custodial deaths provided to the DOJ to evaluate state and BJA compliance with DCRA and make recommendations for sanctions for non-compliant jurisdictions. The committee could also make recommendations to improve state and DOJ compliance by assessing the adequacy of state submissions, identifying suitable sanctions for non-compliant facilities; and reviewing BJA outreach, education, and sanctioning efforts under DCRA.

C. Request to the U.S. Commission on Civil Rights

An increasing number of local and state jurisdictions in the U.S. have voluntarily adopted independent oversight to increase transparency and accountability, including death in custody reporting and review.³³ These oversight bodies collect data, report on, and monitor facilities for compliance with constitutional obligations. The U.S. Commission on Civil Rights (USCCR) is well-positioned to conduct a study of these bodies and make recommendations due to its long history of bipartisan fact finding, study, and recommendations regarding the administration and impact of criminal justice. State advisory committees to the USCCR have submitted reports that

³³ Michele Deitch, *But Who Oversees the Overseers?: The Status of Prison and Jail Oversight in the United States*, 47 AM. J. CRIM. L. 207, 210 (2020).

address prison conditions, incarceration rates, and solitary confinement. The USCCR has produced reports examining the civil rights protections for incarcerated women and the collateral consequences of incarceration.

D. Enact a new law to address legal barriers in litigation

Congress also has the power to shape incentives for detention facilities to reduce deaths in custody by eliminating the judicially-created “qualified immunity” defense for wrongful deaths in custody. Plaintiffs in these cases would still encounter higher standards of proof that are consistent with other types of claims for constitutional violations within detention facilities. Elimination of this doctrine would be a powerful signal that Congress has determined that a facility can not rely on the absence of specific factual predicates to avoid liability for certain deaths in custody.

E. Request to the CDC’s National Center for Health Statistics

Congress can also work with the Center for Disease Control’s National Center for Health Statistics to revise the U.S. Standard Death Certificate to include “in-custody” death option and study the feasibility of a U.S. Standard Custodial Death Certificate (similar to the certificates for Fetal Death). In addition, Congress could require the use of this certificate for jurisdictions participating in DCRA.

Conclusion

Deaths in custody should be rare events. Thus when they occur, it is critical that consistent and trustworthy data is available to understand how and why a person died. DCRA was amended to improve responsiveness and transparency of federal data collection efforts, but has had the opposite effect. Deaths in custody are now more invisible than before implementation of DCRA 2013. I urge this Subcommittee to treat these issues with the urgent attention they deserve. I and others stand ready to provide additional information or support as needed. Thank you for the invitation to share my perspective on these important issues.